DOCKET NUMBER 507-23-24298

IN THE MATTER OF PERMANENT CERTIFICATE NUMBERS 914209 , ISSUED TO MERRI LOU GUZAITIS	**§**	**BEFORE THE STATE OFFICE**
	§	**OF**
	§	**ADMINISTRATIVE HEARINGS**

OPINION AND ORDER OF THE BOARD

TO: MERRI LOU GUZAITIS
c/o BRENDA J. DAMUTH, ATTORNEY
901 MAIN STREET
STE 4800
DALLAS, TX 75202

DEE MARLO CHICO
ADMINISTRATIVE LAW JUDGE
PO BOX 13025
AUSTIN, TX 78711-3025

At the regularly scheduled public meeting on January 30, 2025, the Texas Board of Nursing (Board) considered the following items: the Proposal for Decision (PFD) regarding the above cited matter; Staff's recommendation to the Board regarding the PFD and order; and Respondent's recommendation to the Board regarding the PFD and order, if any.

The Board finds that after proper and timely notice was given, the above styled case was heard by an Administrative Law Judge (ALJ) who made and filed a PFD containing the ALJ's findings of facts and conclusions of law. The PFD was properly served on all parties and all parties were given an opportunity to file exceptions and replies as part of the record herein. No exceptions were filed by any party.

The Board, after review and due consideration of the PFD; Staff's recommendations; and the recommendations made by the Respondent, if any, adopts all of the findings of fact and conclusions of law of the ALJ contained in the PFD. All proposed findings of fact and conclusions of law filed by any party not specifically adopted herein are hereby denied.

Recommendation for Sanction

Pursuant to Tex. Occ. Code. §301.459 (a-1), an Administrative Law Judge may make a recommendation regarding an appropriate action or sanction. The Board, however, has the sole authority and discretion to determine the appropriate action or sanction.

The ALJ found, and the Board agrees, that the Respondent's conduct warrants a second tier, sanction level I sanction for her violations of §301.452(b)(10) & (14).[1] A Warning or Reprimand with Stipulations is authorized for a second tier, sanction level I sanction for a violation of §301.452(b)(10) or (14). The evidence reflects that "minimum standards of nursing practice require more frequent monitoring of the site and lines than the every 15-minute documentation requirement" with regards to visibility of the access site for the entire duration of dialysis.[2] Patient G.C.'s access site was covered by a blanket when blood was discovered that was dripping onto the floor and had been disconnected long enough to allow for the patient's blood to soak the bed.[3] Respondent "failed to visually monitor the patient's access site and lines with sufficient frequency to discover that it had been covered and discover and respond to the disconnection of G.C.'s line."[4]

The ALJ found the following aggravating factors: multiple violations, such as failure to notice the disconnection in time, failure to have the line visible, and leaving the room during the procedure, should have had a level of experience to implement nursing interventions for patient safety (visually monitoring the access site and connections more frequently and having someone sit with he patient), Respondent's prior Board order, patient vulnerability (Patient G.C. was bed-ridden, frail octogenarian with multiple comorbidities who was nonverbal at baseline).[5] The ALJ also found the following mitigating factors: Respondent has been working autonomously since Patient G.C.'s death and evaluations and testimony from her supervisors and physicians.[6]

Therefore, after carefully reviewing and considering the aggravating and mitigating factors identified by the ALJ in this case, the Board has determined, pursuant to the Board's Disciplinary Matrix and the Board's rules, including 22 Tex. Admin. Code §213.33(e)(4), that a Reprmiand with Stipulations is the most appropriate sanction in this case.

The ALJ recommends a Warning against the Respondent's license. The Board disagrees with the ALJ's recommendation and finds that the Respondent should be required to complete a nursing jurisprudence and ethics course, a critical thinking course, and a professional accountability course. These courses should address the Respondent's demonstrated deficiencies and help ensure that future violations do not occur.[7] The Board finds that the Respondent should be subject to direct supervision for one year and indirect supervision for the second year of the order, as well as employer notifications; standard employment restrictions; and quarterly employer reports. These supervisory stipulations are necessary to ensure that any further deficiency in the Respondent's practice will be discovered quickly and remediated appropriately and

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[1] PFD at 47.

[2] PFD at 43.

[3] *Id.*

[4] *Id.*

[5] PFD at 46.

[6] PFD at 47.

[7] 22 Tex. Admin. Code §213.33(f) requires every order issued by the Board to include participation in a program of education, which at a minimum, shall include a review course in nursing jurisprudence and ethics.

serves as guardrails for the Respondent's future patients. Finally, the Board finds that the Respondent should be required to inform her employers of this Order and to submit quarterly employer reports to the Board so the Board can monitor the Respondent's progress and completion of the Order. These stipulations are consistent with 22 Tex. Admin. Code §213.33(e)(4)[8].

IT IS THEREFORE ORDERED that RESPONDENT SHALL receive the sanction of **REPRIMAND WITH STIPULATIONS** in accordance with the terms of this Order.

A. This Order SHALL apply to any and all future licenses issued to RESPONDENT to practice nursing in the State of Texas.

B. This Order SHALL be applicable to RESPONDENT'S nurse licensure compact privileges, if any, to practice nursing in the State of Texas.

C. Until successfully completed, RESPONDENT may not practice nursing in the State of Texas except in accordance with the terms of this Order.

D. As a result of this Order, RESPONDENT'S license(s) will be designated "single state" as applicable and RESPONDENT may not work outside the State of Texas in another nurse licensure compact party state using a Texas compact license.

I. COMPLIANCE WITH LAW

While under the terms of this Order, RESPONDENT shall comply in all respects with the Nursing Practice Act, Texas Occupations Code, §§301.001 *et seq.*, the Rules and Regulations Relating to Nursing Education, Licensure and Practice, 22 TEX. ADMIN. CODE §§211.1 *et seq.*, and this Order.

II. UNDERSTANDING BOARD ORDERS

Within thirty (30) days of entry of this Order, RESPONDENT must successfully complete the Board's online course, "Understanding Board Orders", which can be accessed on the Board's website from the "Discipline & Complaints" drop-down menu or directly at: *http://www.bon.texas.gov/UnderstandingBoardOrders/index.asp*. Upon successful completion, RESPONDENT must submit the course verification at the conclusion of the course, which automatically transmits the verification to the Board.

III. REMEDIAL EDUCATION COURSE(S)

[8] 22 Tex. Admin. Code §213.33(e)(4), which authorizes reasonable stipulations, including remedial education courses and practice for at least two years under the direction of a nurse designated by the Board, as well as limitations on nursing activities/practice settings.

In addition to any continuing education requirements the Board may require for licensure renewal, RESPONDENT SHALL successfully complete the following remedial education course(s) **within one (1) year of the effective date of this Order, unless otherwise specifically indicated**:

A. **A Board-approved course in Texas nursing jurisprudence and ethics** that shall be a minimum of six (6) hours in length. The course's content shall include the Nursing Practice Act, standards of practice, documentation of care, principles of nursing ethics, confidentiality, professional boundaries, and the Board's Disciplinary Sanction Policies regarding: Sexual Misconduct; Fraud, Theft, and Deception; Nurses with Substance Abuse, Misuse, Substance Dependency, or other Substance Use Disorder; and Lying and Falsification. Courses focusing on malpractice issues will not be accepted. Home study and video programs will not be approved.

B. **The course "Righting a Wrong,"** a 3.0 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) International Center for Regulatory Scholarship (ICRS).

C. **The course "Upholding the Standard: Professional Accountability in Nursing,"** a 5.5 contact hour online program provided by the National Council of State Boards of Nursing (NCSBN) International Center for Regulatory Scholarship (ICRS).

In order to receive credit for completion of this/these course(s), RESPONDENT SHALL CAUSE the instructor to submit a Verification of Course Completion form or SHALL submit the continuing education certificate, as applicable, to the attention of Monitoring at the Board's office. RESPONDENT SHALL first obtain Board approval of any course prior to enrollment if the course is not being offered by a pre-approved provider. *Information about Board-approved courses and Verification of Course Completion forms are available from the Board at www.bon.texas.gov/compliance.*

IV. EMPLOYMENT REQUIREMENTS

In order to complete the terms of this Order, RESPONDENT must work as a nurse in the State of Texas, providing direct patient care in a clinical healthcare setting, for a minimum of sixty-four (64) hours per month for eight (8) quarterly periods [two (2) years] of employment. This requirement will not be satisfied until eight (8) quarterly periods of employment as a nurse have elapsed. Periods of unemployment or of employment that do not require the use of a registered nurse (RN) or a vocational nurse (LVN) license, as appropriate, will not apply to this period and will not count towards completion of this requirement.

A. **Notifying Present and Future Employers:** RESPONDENT SHALL notify each present employer in nursing and present each with a complete copy

of this Order, including all attachments, if any, within five (5) days of receipt of this Order. While under the terms of this Order, RESPONDENT SHALL notify all future employers in nursing and present each with a complete copy of this Order, including all attachments, if any, prior to accepting an offer of employment.

B. **Notification of Employment Forms:** RESPONDENT SHALL CAUSE each present employer in nursing to submit the Board's "Notification of Employment" form to the Board's office within ten (10) days of receipt of this Order. RESPONDENT SHALL CAUSE each future employer to submit the Board's "Notification of Employment form" to the Board's office within five (5) days of employment as a nurse.

C. **Direct Supervision:** For the first year [four (4) quarters] of employment as a Nurse under this order, RESPONDENT SHALL be directly supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse. Direct supervision requires another nurse, as applicable, to be working on the same unit as RESPONDENT and immediately available to provide assistance and intervention. RESPONDENT SHALL work only on regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

D. **Indirect Supervision:** For the remainder of the stipulation/probation period, RESPONDENT SHALL be supervised by a Registered Nurse, if licensed as a Registered Nurse, or by a Licensed Vocational Nurse or a Registered Nurse, if licensed as a Licensed Vocational Nurse, **who is on the premises.** The supervising nurse is not required to be on the same unit or ward as RESPONDENT, but should be on the facility grounds and readily available to provide assistance and intervention if necessary. The supervising nurse shall have a minimum of two (2) years of experience in the same or similar practice setting to which the RESPONDENT is currently working. RESPONDENT SHALL work only regularly assigned, identified and predetermined unit(s). RESPONDENT SHALL NOT be employed by a nurse registry, temporary nurse employment agency, hospice, or home health agency. RESPONDENT SHALL NOT be self-employed or contract for services. Multiple employers are prohibited.

E. **Nursing Performance Evaluations:** RESPONDENT SHALL CAUSE each employer to submit, on forms provided to the RESPONDENT by the Board, periodic reports as to RESPONDENT'S capability to practice nursing. These reports shall be completed by the individual who supervises the RESPONDENT and these reports shall be submitted by the supervising individual to the office of the Board at the end of each three (3)

month quarterly period for eight (8) quarters [two (2) years] of employment as a nurse.

V. RESTORATION OF UNENCUMBERED LICENSE(S)

Upon full compliance with the terms of this Order, all encumbrances will be removed from RESPONDENT'S license(s) and/or privilege(s) to practice nursing in the State of Texas and, subject to meeting all existing eligibility requirements in Texas Occupations Code Chapter 304, Article III, RESPONDENT may be eligible for nurse licensure compact privileges, if any.

Entered this 30th day of January, 2025.

TEXAS BOARD OF NURSING

Kristin K. Benton, DNP, RN

KRISTIN K. BENTON, RN, DNP
EXECUTIVE DIRECTOR FOR THE BOARD

Attachment: Proposal for Decision; 507-23-24298 (August 30, 2024)
Staff's Exceptions to the Proposal for Decision (September 12, 2024)
Exceptions Letter (October 4, 2024)

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

August 30, 2024

JoAnna Starr **VIA EFILE TEXAS**

Brenda Damuth **VIA EFILE TEXAS**

RE: Docket Number 507-23-24298; *Texas Board of Nursing v. Merri Lou Guzaitis*

Dear Parties:

Please find attached a Proposal for Decision in this case.

Exceptions and replies may be filed by any party in accordance with 1 Texas Administrative Code section 155.507(b), a SOAH rule which may be found at www.soah.texas.gov.

CC: Service List

SOAH Docket No. 507-23-24298

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
PETITIONER
v.
MERRI LOU GUZAITIS,
RESPONDENT

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SOAH Docket No. 507-23-24298

BEFORE THE STATE OFFICE OF ADMINISTRATIVE HEARINGS

TEXAS BOARD OF NURSING,
PETITIONER
V.
MERRI LOU GUZAITIS,
RESPONDENT

PROPOSAL FOR DECISION

The staff (Staff) of the Texas Board of Nursing (Board) seeks to prohibit Merri Lou Guzaitis from practicing nursing until she completes remedial education classes and, upon completion of those courses, probate the suspension of Respondent's license and allow her to practice with supervision. Staff's recommendation is based on allegations that Respondent violated the minimum acceptable standards of nursing practice and engaged in unprofessional conduct by failing to remain in her patient's room while providing dialysis treatment to her patient, who ultimately died. The Administrative Law Judge (ALJ) concludes that Staff established the disciplinary grounds alleged and recommends that the Board

impose remedial education for violating the minimum acceptable standards of nursing practice and issue a warning with stipulations for engaging in unprofessional conduct.

I. NOTICE, JURISDICTION, AND PROCEDURAL HISTORY

ALJ Dee Marlo Chico of the State Office of Administrative Hearings (SOAH) convened the hearing on the merits by videoconferencing on May 8-9, 2024. Assistant General Counsel JoAnna Starr represented Staff. Respondent appeared, and attorney Brenda Damuth represented her. The record closed on July 1, 2024, after receiving Staff's written rebuttal closing argument. Notice and jurisdiction were uncontested and are addressed solely in the Findings of Fact and Conclusions of Law.

II. FORMAL CHARGES AND APPLICABLE LAW

A. FORMAL CHARGES

Staff alleged the following in its Formal Charges against Respondent:

> On or about May 30, 2022, while employed as a Registered Nurse with DaVita Kidney Care, Coppell, Texas, and proving contract dialysis services for Patient GC at Texas Health Presbyterian Flower Mound, Flower Mound, Texas, Respondent failed to remain in the patient's room for the duration of the patient's 1:1 dialysis treatment. Respondent later noticed blood on the floor, so she and the primary nurse pulled back the blanket that was covering the patient's connection hubs and noticed the dialysis catheter had become disconnected and a significant amount of blood was pooling on the left side of the patient. A Rapid Response Team was called, and later a Code; however, the patient never

regained a pulse and subsequently expired. Respondent's conduct may have contributed to the patient's demise.[1]

Staff asserted the above actions constituted grounds for disciplinary action against Respondent under Texas Occupations Code section 301.452(b)(10) and (14), and 22 Texas Administrative Code sections 217.11(1)(A)-(C), (1)(M), and (3) and 217.12(1)(A)-(b) and (4).

At the hearing and in their briefing, Staff raised allegations that Respondent argued were not set out in the Notice of Hearing or Formal Charges. These include allegations that Respondent failed to document and failed to advocate for G.C. or provide additional nursing interventions due to the patient's prior agitation.

In its written closing, Staff argued that although they were not specified in the charges, they were referenced in the Board rules cited in the Formal Charges. For example, Staff noted that it did not use the term "failure to advocate" but referenced Board Rule 217.11(1)(M),[2] which requires a nurse to institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications. Staff also argued that Respondent did not object at trial to lack of notice and raises her objection the first time in her closing arguments. Finally, Staff contends it met the requirements for fair notice because the notice is only meant to provide the controlling facts of the case and not the details.

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[1] Staff Ex. 3 at 3.

[2] For ease of reference, the Board's rules, found in title 22, part 11, chapters 211 to 228 of the Texas Administrative Code, shall be referred to as "Board Rule _____."

The ALJ disagrees. The Administrative Procedure Act[3] requires that notice of a hearing include a reference to the particular sections of the statutes and rules involved and a short, plain statement of the factual matters asserted against Respondent.[4] The Nursing Practice Act states that the Board may not take any disciplinary action relating to a license unless the Board has served notice to the license holder of the facts or conduct alleged to warrant the intended action.[5] Finally, SOAH's rules require that pleadings be amended not later than seven days before the hearing if a party is to rely on matters that would "unfairly surprise" the other party.[6]

As to the documentation allegations and the "failure to advocate" or intervene based on the patient's prior agitation allegations raised at trial, Respondent did not have a fair opportunity to respond to those new allegations, and the ALJ concludes that they constituted an "unfair surprise." Regarding documentation, Staff neither broached the factual issue or cited to the applicable Board Rule on the topic in the Notice of Hearing.[7] The ALJ also finds that the citation to Board Rule 217.11(1)(M) is not sufficient to provide notice for an allegation that a nurse failed to advocate for a patient or that the failure to intervene due to a patient's prior agitation would be an issue that would need to be addressed at the hearing. Additionally, the cited rule addresses nursing interventions, while other rules address clarifying orders and

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[3] Tex. Gov't Code ch. 2001.

[4] Tex. Gov't Code § 2001.052.

[5] Tex. Occ. Code § 301.454(a)(1).

[6] 1 Tex. Admin. Code § 155.301(b)(2).

[7] Board Rule 217.11(1)(D).

consulting with other members of the health care team.[8] Because the additional issues were not set out in the Notice of Hearing and Formal Charges, they are not appropriate bases for discipline and are not considered by the ALJ.

B. APPLICABLE LAW

The Texas Nursing Practice Act (Act), found in chapter 301 of the Texas Occupations Code, empowers the Board to discipline licensees for, among other things, unprofessional conduct (under Texas Occupations Code section 301.452(b)(10)) or failure to care adequately for a patient or to conform to the minimum standards of acceptable nursing practice in a manner that, in the Board's opinion, exposes a patient or other person unnecessarily to risk of harm (pursuant to Texas Occupations Code section 301.452(b)(14)). Staff asserts that Respondent's conduct is grounds for disciplinary action under both provisions of the Texas Occupations Code, as well as pursuant to Board Rules 217.11 and 217.12.

Board Rule 217.11 discusses minimum acceptable standards of nursing practice. Respondent is subject to sanction under five provisions:

- Board Rule 217.11(1)(A): Failure to know and conform to the Texas Nursing Practice Act and the Board's rules and regulations as well as all federal, state, or local laws, rules or regulations affecting the nurse's current area of nursing practice;
- Board Rule 217.11(1)(B): Failure to implement measures to promote a safe environment for clients and others;
- Board Rule 217.11(1)(C): Failure to know the rationale for and the effects of medications and treatments and correctly administering the same;

[8] *See, e.g.*, Board Rules 217.11(1)(N), (1)(P).

- Board Rule 217.11(1)(M): Failure to institute appropriate nursing interventions that might be required to stabilize a client's condition and/or prevent complications; and
- Board Rule 217.11(3):
    - Failure to use a systematic approach to provide individualized, goal-directed, nursing care by: (i) performing comprehensive nursing assessments regarding the health status of the client; (ii) making nursing diagnoses that serve as the basis for the strategy of care; (iii) developing a plan of care based on the assessment and nursing diagnosis; (iv) implementing nursing care; and (v) evaluating the client's responses to nursing interventions; and
    - Delegate tasks to unlicensed personnel in compliance with Chapter 224 of this title, relating to clients with acute conditions or are in acute environments, and Chapter 225 of this title, relating to independent living environments for clients with stable and predictable conditions

Staff also alleges three types of violations under Board Rule 217.12, which addresses unprofessional conduct:

- Board Rule 217.12(1)(A): Carelessly failing, repeatedly failing, or exhibiting an inability to perform vocational, registered, or advanced practice nursing in conformity with the standards of minimum acceptable level of nursing practice set out in Board Rule 217.11;
- Board Rule 217.12(1)(B): Failing to conform to generally accepted nursing standards in applicable practice settings; and
- Board Rule 217.12(4): Engaging in conduct that may endanger a client's life, health, or safety.

When a nurse has violated the Texas Occupations Code or Board rules, the Board is required to impose a disciplinary sanction.[9] Board Rule 213.33 includes a

[9] Tex. Occ. Code § 301.453; Board Rule 213.33.

Disciplinary Matrix that the Board and SOAH are required to use in all disciplinary matters.[10] The Disciplinary Matrix categorizes violations into tiers, and into sanction levels within tiers, based on the seriousness of the offense and risk of harm to patients or the public. The Disciplinary Matrix also lists certain aggravating and mitigating factors that must be considered. Board Rule 213.33 includes another list of factors that the Board and SOAH must consider in determining the appropriate disciplinary sanction, including evidence of potential harm to patients or the public and evidence of present fitness to practice.[11]

Staff has the burden of proving its allegations by a preponderance of the evidence.[12]

III. EVIDENCE

Staff Exhibits 1-4, 4a, 5-10, and 12-17 were admitted, and Staff presented the testimony from the following witnesses: Bryan Leyster, RN; Bennie Wesley, MA, BA, RN; Dolon Chapa Das, MD; and Christine Renee Riley, MSN, RN.

Respondent's Exhibits 4, 5, 6, and 9 were admitted. Respondent presented her own testimony and the testimony from six additional witnesses: Raghuveer Vanguru, MD; Nishant Jalandhara, MD; Bernadette Christmas, RN; George Rojas, DO; Greg Vazhachira, RN; and Kaylen Johnson, RN.

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[10] Board Rule 213.33(b).

[11] Board Rule 213.33(c).

[12] 1 Tex. Admin. Code § 155.427; *Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 777 (Tex. App.—Austin 2005, no pet.).

A. BACKGROUND[13]

Respondent has been licensed as a Registered Nurse (RN) since January 2017. Shortly after receiving her license, she began working for Life Care Hospital (Life Care) in Fort Worth, a long-term acute care hospital. Respondent did not feel Life Care was a safe place to work because she did not receive the typical training given to new nurses. She was left alone with patients without proper training, did not shadow a preceptor, and had no supervision.

In September 2019, Respondent received a disciplinary action from the Board for her actions in April 2017 regarding medication errors while employed at Life Care. Respondent failed to use two patient identifiers before administering medications to a patient and failed to verify a new physician's order before attempting to administer the medication, which was ordered not to be given until the next day.[14] According to the Agreed Order, Respondent's actions exposed the patients to a risk of harm.[15] The disciplinary action resulted in an Agreed Order Deferred Discipline and completion of the Knowledge, Skills, Training, Assessment and Research (KSTAR) Program.[16] Respondent acknowledged accountability for her actions and completed the terms under the Agreed Order.

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[13] This Background section is derived from Staff's exhibits and Respondent's testimony. Unless otherwise indicated, the background facts were undisputed.

[14] Staff Ex. 3 at 6 ¶¶ 7, 8.

[15] Staff Ex. 3 at 6 ¶¶ 7, 8.

[16] Staff Ex. 3 at 5, 8-9.

This proceeding concerns alleged conduct by Respondent when she was employed as an RN with DaVita Kidney Care (DaVita), acting as the RN assigned to care for G.C. during dialysis on May 30, 2022, at Texas Health Presbyterian Flower Mound (Texas Health Presbyterian). At Texas Health Presbyterian, DaVita dialysis nurses provide one-on-one support for the hospital's dialysis patients because the hospital does not have its own dialysis nurses.

According to her medical record from Texas Health Presbyterian, G.C. was a frail octogenarian who came from a skilled nursing facility and presented in the emergency department for elevated potassium and whose diagnosis included acute renal failure.[17] Her past medical history included chronic kidney disease and dementia.[18] She had a feeding tube for nutrition and was nonverbal at baseline.[19] G.C.'s son declined hospice, and G.C. was started on hemodialysis.[20] On May 14, 2022, G.C.'s medical records noted she kept a fetal position with legs contracted, and she continued to pull herself back into a fetal position when nurses attempted to readjust her.[21] Medical records noted that on May 29, 2022, G.C. was agitated in the morning when given her morning medications:[22] G.C. hit and scratched the registered nurse (RN) and had also hit the certified nursing assistant

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[17] Staff Ex. 10 at 1.

[18] Staff Ex. 10 at 2.

[19] Staff Ex. 10 at 11.

[20] Staff Ex. 10 at 12, 13.

[21] Staff Ex. 10 at 50, 66.

[22] Staff Ex. 10 at 215.

(CNA).[23] Attempts to redirect G.C. were unsuccessful, and she slept on and off during care.[24]

According to G.C.'s medical records from Respondent's entries during her dialysis on May 30, 2022, hemodialysis started at 12:15.[25] Respondent increased the blood flow rate to the ordered rate at 12:30. Hemodialysis was "progressing well" at 12:45. At 13:00, Respondent noted that the lines were visible and secure. At 13:15 Respondent repositioned G.C. The sterile dressing change occurred at 13:30. At each entry, the transducer and access liens were checked.[26]

Before the sterile dressing change, Respondent admitted to leaving the patient's room. Dialysis nurses typically do not leave the patient's bedside. It is the floor nurse who is responsible for assisting and bringing the dialysis nurse whatever is needed. However, Respondent followed the floor nurse to the supply room, and they returned to G.C.'s room after retrieving the dressing change kit.

Respondent made her final entry at 13:40. Respondent had noticed a "small amount of blood dripping on the floor" while she stood at G.C.'s bedside.[27] Nurse Leyster was also at the bedside. When the nurses noticed that the venous lumen catheter, which returns blood back to the body, had been disconnected, they

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[23] Staff Ex. 10 at 215.

[24] Staff Ex. 10 at 215.

[25] According to Respondent, G.C.'s dialysis was scheduled for three hours.

[26] Staff Ex. 9 at 3.

[27] *See also* Staff Ex. 10 at 12, 225.

immediately reattached it.[28] Respondent was unable to obtain blood pressure upon checking the patient. She noted blood pooling under G.C. after removing the bedding from the patient.[29] The rapid response team was called.[30] Respondent attempted to return blood, but there was air in the line. G.C. "had been facing left after repositioning," and Respondent stated that the lines were visible. A Code Blue was called but was unsuccessful in resuscitating, and G.C. passed.[31]

Both parties agreed that all patients deserve the same standard of care when dialyzed, even if they have a poor prognosis. No one had issues regarding the timeliness or appropriateness of Texas Health Presbyterian staff's response during the rapid response or Code Blue.

DaVita investigated the May 30, 2022 incident and gave Respondent a verbal warning for leaving G.C.'s room to get a sterile bandage but did not discipline her for the line disconnection. Respondent has continued to work for DaVita after the May 30, 2022 incident, because DaVita determined her actions did not warrant termination. She has not left a patient unattended since that date. She also does not have any other corrective action or sanctions in her personnel file, but she has received accolades for her professionalism and patient care since then.

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[28] *See also* Staff Ex. 10 at 12.

[29] With G.C.'s dialysis catheter disconnected, it allowed a "significant" amount of blood to be lost into the bed. Staff Ex. 10 at 9, 225.

[30] *See also* Staff Ex. 9 at 3.

[31] Staff Exs. 9 at 3, 10 at 9, 12.

1. Dialysis and DaVita's Policies[32]

Dialysis is as a procedure that ensures the state of homeostasis by removing toxins and excess fluids from the blood of a patient with kidney failure. The procedure can last three to five hours, depending on the size and need of the patient.

There are two types of dialysis, and the one performed on G.C. was hemodialysis, which uses a machine to remove blood from the patient's body through two lines: One line (arterial side) removes the blood from the patient through the patient's access point and takes it to the machine where the blood is filtered and toxins are removed through a dialyzer (artificial kidney). The other line (venous side) returns the clean blood back to the patient. If these lines are not visible and consistently monitored during hemodialysis, the patient can quickly lose blood and bleed out if a line becomes dislodged.

The transducer is a filter inside the dialysis machine. There is one on the arterial side (i.e., before the blood goes into the dialyzer) and one on the venous side (i.e., where the blood comes out of the dialyzer). The transducer measures the arterial and venous pressures. It keeps the blood side of the circuit from contaminating the machine side.

Dialysis is inherently risky. The Board's experts assert that a patient can suffer multiple side effects during the removal of blood. The patient can develop nausea,

[32] The nephrology experts and nurse witnesses described the process of dialysis as well as the dialysis nurse's role and responsibilities during the process. The witnesses did not dispute DaVita's dialysis treatment policies, which further describe the dialysis nurse's role.

vomit, or become hypotensive (low blood pressure), which can lead to shock. Second, the dialysis machine can malfunction, and the dialysis lines can disconnect. Third, a patient's medical condition—such as a patient with multiple comorbidities (e.g., heart disease, low blood pressure, frailty)—and patients with certain challenges—such as patients who are agitated, demented, delirious, or mentally challenged—would also make them higher risks when undergoing hemodialysis. Finally, every slight change in a patient's condition or demeanor can signal a problem, so the dialysis nurse needs to be aware of the patient's condition throughout the treatment. For example, a patient yawning could mean their blood pressure is dropping, indicating a possible problem and putting the patient at risk.

DaVita's policy on dialysis treatment requires treatment checks and documentation every fifteen minutes (plus or minus five minutes). At a minimum, the documentation must include: the patient's blood pressure, heart rate, and that vascular access is visible and line connections are intact.[33] DaVita's policy prohibits patients from being left unattended and requires patients to be monitored "visually and audibly at all times."[34] Throughout the dialysis treatment, DaVita's policy requires the vascular access site and the blood line connections to be continuously visible because, if covered, it creates opportunities for accidental needle dislodgement or a line disconnection to go undetected.[35]

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[33] Staff Ex. 7 at 6 ¶3.

[34] Staff Ex. 7 at 6 ¶5.

[35] Staff Ex. 7 at 6 ¶6.

B. STAFF'S CASE

1. Testimony of Nurse Leyster

On May 30, 2022, Mr. Leyster worked as a medical surgical nurse at Texas Health Presbyterian. That day he was the primary nurse responsible for providing direct patient care for four to six patients. Mr. Leyster found G.C. to be alert and understand what was going. She laid in bed all day in a contracted position—knees to her chest and arms also tucked up to her chest with her hands in the middle of her chest—unable to feed or provide for herself. He said G.C.'s contracture prohibited her from having a full range of motion of her limbs. Although she could move her arms out a few inches, she could not fully extend them, and they always returned to her chest.

Regarding the events on May 30, 2022, Mr. Leyster served as G.C.'s primary floor nurse responsible for her personal care needs and providing supplies for the dialysis nurse when needed. Mr. Leyster testified that when the dialysis nurse arrived, he would give a report on the patient, which included his experience with the patient. G.C.'s hemodialysis started around 12:00-12:15 p.m. During the dialysis, Mr. Leyster observed Respondent located next to G.C. on her left side at the head of her bed next to the dialysis machine and within arm's length of G.C. He said Respondent would stay in that position—where she could observe the patient, machine, and the vital signs—during the dialysis treatment. He had no criticism of Respondent regarding her care when he administered G.C.'s medications nor while she changed G.C.'s dressings. Mr. Leyster said Respondent came across as a compassionate, caring nurse.

Mr. Leyster observed Respondent take a phone call during the first hour of dialysis when he gave G.C. her medications. While on the phone, he observed Respondent remained in position—on G.C.'s left side of the bed. Respondent's conversations, he said, sounded work-related since it related to scheduling staff assignments.

Mr. Leyster first noticed something wrong when he returned to the room around 1:40-1:45 p.m. He noticed blood, "not very much," dripping on the floor on the left side of G.C.'s bed close to where Respondent stood. Respondent then saw the blood herself. G.C., who was sitting up a bit due to the bed being tilted up, had the blankets pulled up to her chin. When they pulled the blanket down, they noticed a puddle of blood on G.C.'s left side at her hip that had started overflowing and dripping onto the floor. He noted the sheets, blanket, and bed had absorbed some of the blood. Mr. Leyster testified G.C. lost "a lot" of blood.

They then began assessing her. Mr. Leyster testified G.C. was initially alert but progressed to being unresponsive. They hit the rapid response button, which is the first line of escalation. After failing to get blood pressure a second time, they hit the Code Blue button. When the Code Blue team showed up, they took over and he assisted them in whatever they needed while their documenter charted the series and the sequence of events.

2. Testimonies from Staff's Nephrology Experts

Dr. Das, who is board certified in nephrology, deals with both chronic and acute dialysis patients and is the Board's expert in nephrology. Ms. Wesley, the Board's expert in dialysis nursing, has been certified as a nephrology nurse for 26 years. Both also testified as experts regarding the standard of care for nephrology nurses.

Ms. Wesley testified that the risk related to G.C.'s contracture in her arms is depending on the type of access (i.e., catheter) she had. The crux though is to be careful with the placement of the lines and to make sure the lines are kept away from her hands. More specifically, Dr. Das opined that G.C.'s contracture would be concerning during hemodialysis because G.C.'s dialysis catheter was positioned in her chest area where her body folds into. He posited that G.C. could possibly obscure the catheter's visibility or, because of her agitation and contracture, pull the catheter out or pull out the access ports to the catheter. And since G.C. had experienced treatment complications (e.g., there was at least one incident where her blood pressure dropped), she would need more vigilance keeping her access visible. Dr. Das also mentioned that the Association of Nephrology Nurses Association's (ANNA's) recommended standard of care for high-risk patients includes monitoring (e.g., using a family member or sitter at the facility), more frequent checks than recommended, or using an experienced nurse with dialysis knowledge who would know the patient would require more attention. Both experts, however, agreed that during dialysis, the dialysis nurse has a duty to inform the physician if a patient is being agitated or refusing care so that a plan of action can be devised.

Both experts testified that nurses cannot leave their patients unattended during dialysis treatment. It is the responsibility of the nurse to keep the patient safe for the entire time they are on the dialysis machine. The nurse has to have a constant visual line of sight on the patient and the machine in order to respond to whatever type of emergency may happen. Only when nurses have someone in place for them to watch the patient while they are gone can nurses leave a patient on hemodialysis. Dr. Das also testified about End Stage Renal Disease (ESRD) Networks Medical Advisory Council standard requiring a dialysis staff member, a patient care assistant, or an RN within sight of the patient at all times.

Ms. Wesley admitted she did not know how long Respondent was out of the room, the distance to supply room from G.C.'s room, or G.C.'s condition when Respondent left the room. Nothing she reviewed led Ms. Wesley to believe that Respondent's time out of the room led to the disconnection of G.C.'s lines.

While Dr. Das was not concerned by a nurse on the phone during a patient's hemodialysis treatment, Ms. Wesley had some reservations because it takes away the nurse's ability to focus on the patient. Yet she also said that nurses can answer a call to say they cannot talk until after the treatment, but if the caller cannot wait, then the nurses can ask someone to cover for them while they take the call.

Both experts agree that it is important the lines remain visible throughout dialysis. Referencing DaVita's policies, Ms. Wesley noted (1) that dialysis nurses must not only be able to view the patient and machine at all times but also hear the patient and the machine and (2) that the access site and line connections be

continuously visible throughout the dialysis treatment because covering either would provide an opportunity for accidental needle dislodgement or a line disconnection to go undetected. As Dr. Das explained, when a patient's lines or access site is uncovered, it gives the nurse a way of surveying whether the dialysis machine to patient circuit is complete. Dr. Das asserts that someone performing hemodialysis would notice if a line became covered right away if they are following the policy and guidelines for keeping the access visible at all times. Ms. Wesley testified that DaVita's policies are in line with federal standards for dialysis (i.e., nurses must be able to be see the access site and connections throughout dialysis treatment)[36] and acknowledged that DaVita's policy does not require dialysis nurses to keep their eyes on the line connections every moment.

Another standard Dr. Das mentioned that came from the ESRD Networks Medical Advisory Council is that the connections of the hemodialysis access should always be uncovered and visible. ANNA's taskforce also investigated venous needle dislodgement and access bloodline separation and formulated recommendations on how to avoid these "catastrophic situations," such as more frequent patient checks or bringing in another individual who could help stabilize the patient since it is not unusual that the nurse may have to answer phone calls or have to address certain issues with the dialysis machine. However, Dr. Das agreed that having the access site uncovered and visible (i.e., capable of being seen) during the duration of the dialysis treatment does not mean that the nurse stares at the site every moment. Rather, when the nurse looks at the access and bloodline connections, he clarified they must be visible.

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[36] *See* Staff Ex. 17 at 13.

Dr. Das and Ms. Wesley acknowledged that dialysis nurses have other duties besides watching the patient: responding to alarms on the machine; documenting every 15 minutes (which is both the standard of care for DaVita and the recommendation in the ESRD toolkit that they testified Respondent followed during G.C.'s treatment); administering medication as ordered by the nephrologist; troubleshooting the machine if there are issues with it; calling for assistance, if needed; talking to a healthcare provider who enters the room; repositioning the patient, if necessary; and changing a bandage, if necessary. They also recognized that patients move during dialysis, are entitled to have blankets if cold during dialysis, and can reach over and pull a blanket up in a matter of one to two seconds. Even if a nurse—while looking at and standing next to a patient—could not prevent the patient from covering the access site or lines, the nurse must remove the blanket to make sure that the access is visible. Ms. Wesley also recognized that sometimes patients can move that blanket very quickly, shifting the blanket up within a second or two. Dr. Das conceded that a patient can quickly cover the site or lines while the nurse is watching the patient.

According to Ms. Wesley, the first time the patient covers their access site, the nurse should educate the patient, if they can, and then watch them closely. If they do it a second time, the nurse should document it. If the patient does it a third time, then the nurse can possibly—if the nurse feels she needs assistance—call the doctor to request interventions to assist the patient. Ms. Wesley contends the decision is ultimately based on the nurse's critical judgement since the nurse was there at the time dealing with the situation. In this case, Ms. Wesley did not see any evidence that G.C. uncovered her access a second or third time.

a) Additional Testimony of Dr. Das

Based on G.C.'s weight (41 kilograms or about 90 pounds), Dr. Das calculated she had approximately three liters of blood in her body. She also had 350 milliliters outside her body at any time during her dialysis. He estimated it would take three minutes for her to lose an entire liter of blood. He testified that each person has a different threshold for what they can sustain during blood loss because it depends on various factors, such as other comorbidities. However, in general, a person can lose about 15 percent of his or her blood without any major side effect but may feel lightheaded or a little dizzy. People can start feeling symptoms like nausea, heart racing, or sweaty when they lose up to 30 percent of their blood. After 30 percent, he said people can get low blood pressure, start to pass out, or go into a state of shock.

He could not say whether G.C. lost over 30 percent of her blood because he did not know how long she bled. However, based on the medical records, ten minutes had passed without knowing whether the lines were dislodged. He opined that ten minutes is more than ample time for G.C. to lose over 40 percent of her blood and for her to exsanguinate[37] since her threshold for blood loss would be lower than a healthier, larger patient. However, he admitted that it is not known what happened during those ten minutes. Nevertheless, he testified that blood loss caused the Code.

In his expert opinion, Respondent did not meet the standard of care for G.C. First, she failed to keep the access point visible at all times because G.C. had her blanket covering it. Second, she failed to attend to G.C. at all times because

[37] In other words, bleed out.

Respondent left the patient's bedside without leaving G.C. with any other care provider.

b) Additional Testimony of Ms. Wesley

Ms. Wesley testified that the role of the dialysis nurse during acute dialysis treatment is to become very knowledgeable about the patient, have great communication skills with everyone involved in the care of the patient, and be knowledgeable of the practice of dialysis, the Nurse Practice Act, and hospital policies. She noted that an acute dialysis nurse's role is very complex, very demanding and not everyone can do it since it takes a certain type of nurse who wants to participate in that kind of care. Her review of Respondent's performance evaluations at DaVita revealed that Respondent's supervisor had written she needed to pay more attention to detail, but Ms. Wesley stated an acute dialysis nurse's role is often rushed due to the complexity of the role.

According to Ms. Wesley, a nurse's duty to document is based on the hospital's policies. Here, it is every 15 minutes, plus or minus five minutes. However, that 15 minutes is the minimum. Dialysis nurses, she said, will have to use their critical thinking to determine whether they need to document more often. For example, the nurse may want to do more frequent checks, and, therefore, more frequent documentation, if a patient's heart rate changes because it can be an indicator that the heart is not being furnished blood. In addition to documenting blood pressure, heart rate, and respirations, the nurse is looking at the machine and its settings (e.g., blood flow rate, dialysate flow rate, transducer pressure), the access

site (e.g., whether it is visible), and the patient to ensure lines and the access site are not covered.

Ms. Wesley opined that if patients are unable to communicate their needs, a nurse providing one-on-one dialysis should be able to take care of the patient's needs or, if the nurse does not understand the patient, the dialysis nurse can ask the bedside nurse to help figure out what is going on with the patient. And unlike a nonverbal patient, a patient with dementia—depending on the level of dementia—may be able to communicate that their line has become disconnected.

In Ms. Wesley's expert opinion, Respondent violated policy and acted below the standard of care when she failed to monitor the access site, when the access site became covered with a blanket, and when she took several phone calls during dialysis treatment.

C. RESPONDENT'S CASE

1. Testimony of Respondent

Nursing is a second career for Respondent. She began working for DaVita in May 2017 and currently works as an acute dialysis nurse, charge nurse, and preceptor. As a charge nurse it is her responsibility to make sure treatments or the assignments that come in are covered and to take phone calls, which usually did not take long. If she was engaged in something that would cause her to believe it was unsafe to take a call, Respondent said she would not take a call or tell them to she would call back.

Before she starts dialysis, Respondent said she does an assessment, reviews the patient's order, brings the dialysis equipment into the room if dialysis is done bedside, connects the water sources, and goes through the dialysis machine's safety checks. May 30, 2022, was her first exposure to patient G.C. Respondent testified she reviewed G.C.'s medical records and spoke to her bedside nurse (Mr. Leyster).

Respondent testified she checked the access and line connections every 15 minutes as she noted in the DaVita's flow sheet for G.C. She also clarified that G.C.'s dialysis access was on her right, not left, chest wall. When Respondent left the room "for about two minutes" to get the sterile dressing, G.C. was asleep and remained asleep when she returned. Since May 30, 2022, Respondent affirmed she has not left a patient's room or otherwise left a patient unattended.

Respondent testified that G.C. was only agitated when they physically had their hands on her. In between care, G.C. would fall into a deep sleep. Respondent also did not see G.C. touch the connection hubs or pull on her connection lines.

After a second set of interventions, Respondent pulled up a stool to sit and hold G.C.'s hand while she reassured G.C. that they were done for a while and that G.C. was okay. Respondent held her hands until G.C. fell asleep. While Respondent sat next to G.C., she was still able to see the line connections, because they had repositioned G.C. so that her access site faced up.

About five or six minutes after sitting next to G.C., Respondent received a phone call. Respondent believed it was safe to take the call because G.C. was sound

asleep and not moving. Respondent had received a call about a patient at Presbyterian Denton. The first call lasted about a minute or two: a nurse had called about a new patient in the emergency room who needed to be urgently dialyzed. Respondent testified that an urgent dialysis is a serious matter, and a patient can die if not dialyzed. The second call lasted less than a minute. When finished with the first call, Respondent said she hung up and called another nurse to asked when the nurse would be done with her current treatment and if that nurse could take care of the patient. The third and final call was made to the original nurse to tell her which nurse would take the patient.

During the call, Respondent said she stood up and backed away from the bed towards the end of the bed to avoid waking G.C. since she was calmed down and sleeping soundly. When she left the stool and backed away from the bed, G.C.'s lines were still visible and intact.

Respondent testified that she would look at the line connections more than every 15 minutes, especially since G.C. had a one-on-one dialysis treatment protocol. However, she did not document every time she observed G.C.'s line connection. If she had, she said she would not have time to actually care for the patient. However, Respondent admitted that she did not have her eyes on the lines and access point the entire time she was on the phone. Respondent believed she did not visualize G.C.'s lines for a minute or two, but she recalls looking at G.C.'s access point during the calls and seeing the lines.

When Mr. Leyster returned to the room, she said she had possibly just hung up the phone and was still standing at the end of the bed. Upon his entrance, they noticed a couple of drops of blood on the floor. The blanket had somehow covered the access site. They pulled the blanket back and saw the line disconnected. Respondent thinks the disconnection occurred between 13:30 and 13:40 but does not know exactly when it actually disconnected.

Respondent reconnected the lines and tried to restart the blood pump to recirculate it and get the blood back to her, but there was air in the line. She also tried to "recirculate the blood pressure." At the same time, Mr. Leyster was also trying to assess G.C. He was talking to her and noticed G.C. was still conscious and tracked with her eyes. During this time, they also repositioned the blood pressure cuff to try to get blood pressure on another limb. Mr. Leyster called the monitor room and found out that, at that time, G.C. was still in normal sinus rhythm and had a pulse.

When the hospitalist came in, they told the hospitalist the patient's line had become disconnected, G.C. had some blood loss, and had not waken up like before. The rapid response team was contacted just after hospitalist arrived. Upon their arrival, Respondent stood back, answered questions, and stayed out of the way.

Respondent has always been vigilant about looking at access sites and line connections as well as assessing patients. Since the incident, Respondent testified that she has become "hyper vigilant." When thinking about what she could have done differently on the day in question, Respondent mentioned never turning away from the patient but did not believe it possible since she cannot stare at the

connection lines the entire time while performing her other duties. Even when she has taken care of two dialysis patients at a time, Respondent said it was impossible for her to keep her eyes on the line connections for two patients at the same time. She did, however, learn that catastrophes can happen quickly, patients need to be attended the entire time, and she needs someone next to a patient—no matter how brief—if she steps away. She has taken this experience as a cautionary tale and passed it on to the other nurses that she trains.

2. Testimony of Respondent's Supervisors

Mr. Vazhachira is Respondent's current supervisor, and Ms. Johnson is Respondent's former supervisor. Both have worked as acute dialysis nurses. Mr. Vazhachira currently serves as DaVita's hospital services administrator but continues to provide acute dialysis care depending on the patient load. As the hospital services administrator he monitors or audits all dialysis treatment and manages the RNs on his team (the Denton team).[38] He also manages DaVita's dialysis contracts with five facilities in the Denton area.[39] Ms. Johnson currently serves as a DaVita group hospital services administrator. Her duties include overseeing 17 hospitals in the Dallas-Fort Worth and East Texas areas, providing oversight to five hospitals, supervising other administrators, and monitoring and auditing DaVita teammates.[40] She was Respondent's supervisor prior to Mr. Vazhachira and originally hired

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[38] The Denton team consists of dialysis nurses—including Respondent—who practice in the Denton geographical area.

[39] DaVita contracts dialysis services to hospitals.

[40] DaVita calls its employees "teammates."

Respondent. Although no longer her supervisor, Respondent remains under Ms. Johnson's chain of command.

Both have had opportunities to evaluate Respondent in a clinical setting since they each visit their nurses at least once a week. Mr. Vazhachira also had the opportunity, while he served as a clinical coordinator, to work alongside Respondent.

Ms. Johnson differentiated between an acute dialysis nurse and a clinic, or chronic, dialysis nurse. Acute dialysis nurses, she said, must be flexible because they have unpredictable work schedules, and they work autonomously. They are oftentimes the only dialysis nurse in a given hospital. Chronic dialysis nurses, on the other hand, have a more regimented schedule with set work hours and set days and have other dialysis professionals (e.g., RNs, LVNs) with them. Mr. Vazhachira and Ms. Johnson both testified that Respondent the descriptors of an acute dialysis nurse.

Mr. Vazhachira identified the roles Respondent held at DaVita: dialysis nurse, charge nurse, and preceptor. As a charge nurse, Respondent puts together the monthly schedule for the Denton team as well as sends a scheduling list for the day since the five hospitals the Denton team serves have fluctuating patient censuses. Respondent triages the patients to determine which ones need dialysis urgently or first thing in the morning, as well as schedules the new patients admitted at the hospitals. As a charge nurse, Respondent is responsible for scheduling any time of the day based on the urgency. Mr. Vazhachira testified that Respondent is exemplary in her capabilities as a charge nurse, and he has had no issues with her performance.

Additionally, as a preceptor for the last two or three years, Respondent has precepted most of his new team members. He characterized her as one of his expert preceptors.

As Respondent's current supervisor, Mr. Vazhachira conducted her 2023 performance evaluation covering the period of April 2022 through March 2023 and gave her the highest rating of "high performing."[41] He expects, as of the date of his testimony, to give her the same rating for her overall evaluation in her 2024 evaluation. He also believed DaVita would have promoted Respondent had the Board not made allegations against Respondent.

As Respondent's former supervisor, Ms. Johnson conducted her 2021 and 2022 evaluations. She gave Respondent a rating for four, which means "exceeds expectations," out of a possible five, which is the highest level an employee could receive at that time. Ms. Johnson said she never gives a five because she believes there is always room for growth and improvement.

DaVita's evaluations include assessing how teammates "Live the DaVita Way" and exhibit the "WE CARE" behaviors. "Living the DaVita Way" means conforming to core values and behaviors that all DaVita teammates are encouraged to exhibit: service, excellence, integrity, team continuous improvement, accountability, fulfillment, and fun. "WE CARE" stands for "Welcome, Empathize, Connect, Actively listen, Respect, and Encourage" and is only considered for team members who interact with patients. Mr. Vazhachira testified that Respondent naturally demonstrated "Living the DaVita Way" and the "WE CARE" behaviors

[41] *See* Respondent Ex. 4 at 9-12.

while Ms. Johnson noted Respondent "bleeds" the DaVita way and continually exhibits those core values and caring behaviors.

Ms. Johnson also clarified that there are sections in the evaluation that supervisors must complete as part of the performance review process and are not indicators of an area of underperformance. Rather, supervisors are encouraged to find even the smallest things that could help the nurse improve or grow. In Respondent's 2020 evaluation, Ms. Johnson commented that Respondent needed to pay more attention to detail. Ms. Johnson's message to Respondent when she wrote that comment was to remind Respondent to slow down and ensure that she looks at all of the details and not because she had any issues with Respondent failing to pay attention to details.

Ms. Johnson noted Respondent is a Certified Nephrology Nurse whom Mr. Vazhachira considers an expert dialysis nurse and a leader on his team. He describes her as the "heart and soul" of the team who ensures the Denton team delivers the greatest dialysis care and who is Mr. Vazhachira's eyes and ears at the hospitals. Ms. Johnson opined that this is not just a job for Respondent, but a passion.

Like Ms. Johnson, Mr. Vazhachira believes nurses continue to grow and improve through their career. Both noted Respondent's commitment to grow personally and professionally and learn through the leadership programs she has completed and conventions she attended where she brought back information she learned to her teammates. They also noted Respondent's dedication to her team. Respondent is always the first one to welcome a new dialysis teammate. She also

tends to be the one willing to help when the Denton team or the greater DaVita team needs help. For example, Respondent picks up shifts on her days off. She is also one of the first dialysis nurse sent out to tough dialysis sessions or to very critical patients who may need a nurse with more experience in dialysis care. And, since she is credentialed in a wide geographical area, Respondent has traveled up to six hours away to support another team that was short staffed. She is also part of the Cyclone Team, which is a group of DaVita teammates who are deployed to natural disaster areas to dialyze patients and ensure those patients are taken care of during a natural disaster. According to Mr. Vazhachira, not all nurses travel to help other centers and it takes a very flexible and very driven nurse to be able to accomplish travel. Ms. Johnson also noted how her clinical coordinator directly contacts Respondent to see if there is any opportunity to help out in their area.

As for Respondent's care of her patients, they described her being an advocate for the patients. Respondent welcomes everyone, communicates well with others, connects with her patient and team, and respects those around her.

Mr. Vazhachira and Ms. Johnson are familiar with DaVita's intradialytic treatment monitoring policy and the provision requiring the access and bloodline connections be monitored every 15 minutes and be continuously visible throughout the dialysis treatment. Regarding the need to be "continuously visible," Mr. Vazhachira interprets it to mean that the access and bloodline connections need to be capable of being seen throughout the treatment. Mr. Vazhachira and Ms. Johnson clarified that the policy does not require dialysis nurses to keep their eyes glued on the patient's bloodline connections every moment of the treatment,

because it is not feasible due to the other roles of the dialysis nurse during the treatment. For example, a dialysis nurse troubleshoots the machines, gives medications, charts on the computer, and may do an assessment on the patient that would require the nurse to take their eyes off the access site or lines. Thus, to meet the requirement that the access lines be continually visible during a dialysis treatment, the nurse must be glancing at the access site and bloodlines throughout the treatment.

Also, the dialysis nurse is not required to document except for every 15 minutes. Thus, if between those fifteen-minute periods the nurse saw that something covered the line, the nurse would immediately uncover it but would not necessarily have to document it since the nurse is performing other duties at the same time. Outside of the May 30, 2022 event, Mr. Vazhachira has not had any complaints about Respondent's monitoring of the bloodline connections.

Both reviewed Respondent's chart on the day of May 30, 2022, and maintained that Respondent did the 15-minute checks and documentation of the line connections as required by policy. In their opinion, Respondent complied with the standard of care regarding her documentation and assessment of those line connections. They both testified that a majority of patients move during dialysis, and it is not unusual for patients to cover the connection hub with a blanket, which can take a second or two. They asserted it was possible for patients to cover the line connections when nurses are performing some other duty or responsibility that takes their eyes off the patient or even when the nurse is directly looking at the patient. According to their policy, when nurses discover that the connection lines are

covered, their responsibility is to immediately remove the barrier to so that the connection hubs are visible again. Ms. Johnson noted that it is not possible for a dialysis nurse to absolutely prevent the connection lines from becoming uncovered.

Mr. Vazhachira testified that a line disconnection can happen quickly. It can even occur when a dialysis nurse is providing reasonable and prudent nursing care. If a line disconnection or a venous needle gets pulled out, a reasonable dialysis nurse would reach out to the nearest person available who may be a dialysis nurse if they were in a dialysis suite. Since most of DaVita's patients are alone, their dialysis nurses would call the primary care nurse, a charge nurse, or anybody they can easily contact in the hospital. If this type of event occurs, Ms. Johnson testified it becomes a medical emergency as opposed to a dialysis emergency.

On May 30, 2022, Ms. Johnson said Respondent was charge nurse that day. As a charge nurse, she is notified of new patients and acts as a scheduler for their hospitals; thus, it is important for Respondent to respond to calls. Ms. Johnson is aware that Respondent received a telephone call regarding scheduling a new patient. Respondent would have had to answer the phone within a reasonable amount of time and sent a nurse to perform the dialysis. Because some patients admitted to hospitals need urgent dialysis and can die if not dialyzed in time, a charge nurse's response time must be fast.

3. Physicians' Testimonies

Drs. Vanguru, Jalandhara, and Rojas are physicians specialized in the field of nephrology for over a decade. In addition to testifying on behalf of Respondent,

Drs. Vanguru and Rojas had written letters to the Board regarding her.[42] Drs. Vanguru and Jalandhara work with Respondent at Texas Health Alliance, while Dr. Rojas knows her from her work at the acute dialysis program at North Texas Kidney Disease Associates.

Each have observed Respondent perform her duties as an acute dialysis nurse taking care of their inpatient dialysis patients. Although not present for the entire treatment, they have been present for up to fifteen minutes at a time while she actively administered hemodialysis to a patient (and up to thirty minutes for Dr. Rojas with his intensive care unit (ICU) patients). They are not familiar with the Nursing Practice Act, but they are familiar—through their observations of Respondent—with her nursing abilities and clinical skills.

They described her as a "very good" nurse who is involved and who has "very good" relationships with the patients under her care. Dr. Rojas testified Respondent does an "excellent job" as a dialysis nurse. Drs. Vanguru and Jalandhara placed her in their top percentile of nurses they have worked with because of her ability to relate to patients, her reliability, and, for Dr. Jalandhara, his confidence in her clinical skills.

Regarding her nursing abilities, Dr. Vanguru and Dr. Rojas testified Respondent has very good clinical judgment as a dialysis nurse. The physicians testified Respondent is diligent in timely communicating any concerns about her

[42] *See* Respondent Exs. 5, 6.

patients and in taking care of them. They also said Respondent pays attention to details and goes out of her way to educate and care for the patients.

4. Testimony of Bernadette Christmas, RN

Ms. Christmas has been a licensed RN since 1997 who, although not certified as a dialysis nurse, has worked as an acute dialysis nurse. She is Respondent's expert the standard of care for acute dialysis nurses.

Ms. Christmas testified that Respondent documented every 15 minutes, which is within the standard of care for a nurse. Respondent's documentation included that bloodline connections were visual, which is also in compliance with DaVita's policies. And Respondent's action of taking a phone call during G.C.'s dialysis was part of Respondent's job as a charge nurse and within the standard of care. However, her leaving the room to get a dressing was not, in Ms. Christmas's opinion, in compliance with the standard of care. Yet, she opined that Respondent's act of leaving the room had nothing to do with the line disconnection that later occurred.

Regarding the issue of "visibility" and the 15-minute documentation intervals, Ms. Christmas defined "visibility" to mean it the lines are capable of being seen and not so much that the nurse is watching the lines the entire time. In her experience, nurses "periodically" check and scan the patient and machine between their 15-minute checks while performing their other duties, such as documenting the nurse's observation of the lines and blood pressure and addressing any healthcare provider (nephrologist, dietitian, primary care nurse) who walks into the room.

Nurses also do not document every time they put their eyes on the bloodline connections.

The fact that a patient is pinching and pulling a nurse during a dressing change near the access site can be an indication that that patient could reach the access site such that disconnection becomes a concern. In her opinion, does not necessarily increase the frequency that a nurse must glance at the connection lines. For example, a catheter, unlike a needle, is not as easily pulled out because it is tunneled and sutured making it hard to come apart, especially at the connection hubs between the catheter and the bloodlines. G.C.'s access site had a tunneled catheter on the right side. Ms. Christmas asserts that to connect the catheter to the bloodline, the line is inserted by twisting it. It does not take a lot of strength to disconnect the blood line to the access site. However, Ms. Christmas believed G.C. could have survived if her disconnection had been caught immediately.

Regarding taking a phone call during dialysis, Ms. Christmas clarified that it would not alarm her if a dialysis nurse, who has a patient with heightened risk factors for disconnection, takes a phone call because sometimes a nephrologist calls and may want to change orders or maybe the nurse has to call the nephrologist. If a call is related to scheduling a different patient, the call can also be important if it is an urgent patient. It could be the difference between life and death for the patient they are trying to schedule. Ms. Christmas opined that a phone call could be important, and it does not hurt to answer it as long as the nurse is not on it for personal reasons.

D. TESTIMONY ON SANCTION LEVEL AND THE SANCTION

Ms. Riley testified the Board has developed guidance for nurses regarding their duty in any setting. Patient safety is paramount in nursing. Thus, when a nurse is in a situation where there is a risk to the patient, the nurse has a responsibility to intervene and make efforts to stabilize the patient. Nurses must also have adequate experience, education, and training to accept a particular assignment. One critical function of a nurse is to use their nursing judgment: nurses must also be able to recognize risk factors and make safe interventions in the best interests of their patients. The physician relies on the nurse's assessment since the nurse, unlike the physician, typically spends the most time caring for the patient. The nurse's judgement or decisions, according to Ms. Riley, will be informed by the condition of the patient at a particular time and the nurse's knowledge and experience in nursing interventions.

Ms. Riley raised three issues of concern regarding Respondent. First, Respondent's inability to offer specific actions—other than not leaving the room and being hyper vigilant—she could have taken to avoid the outcome that transpired on May 30, 2022. Second, Ms. Riley said Respondent sounded unfamiliar with components of the dialysis equipment, specifically the transducer, and what she was documenting.[43] Nurses, she said, need to know what they are documenting and be familiar with the equipment used. Finally, she is concerned about Respondent's ability to train other nurses. With Respondent's years of nursing experience in

[43] Respondent initially testified during Staff's case in chief on the first day of the hearing that she did not know what a "transducer" means, but during her testimony in her case in chief the next day, she was able to define it, explaining she was "a little thrown" because Staff's witness had referenced a dialysis machine the hospital did not have. *Compare* Transcript (Tr.) Volume (Vol.) 1 at 116-17 *with* Tr. Vol. 2 at 72-74.

providing dialysis care, she should have the skill and competence to teach and know the parts of a dialysis machine and know the applicable guidelines in her practice setting.

Ms. Riley testified Respondent violated Texas Occupations Code section 301.452(b)(10) and (b)(14). She specifically identified Board Rule 217.11(1)(A), (1)(B), and (M) as the standards of nursing practice Respondent failed to meet. Ms. Riley also identified Board Rules 217.12(1)(A), (1)(B), and (4) as the unprofessional conduct Respondent exhibited.

Referencing Ms. Wesley's testimony, Ms. Riley reiterated how Respondent violated the minimum standard of care based on federal rules and regulations that nurses are supposed to uphold for dialysis care and which require that the access site and connections be visible to the nurse throughout the dialysis treatment.

Ms. Riley also did not believe Respondent's actions promoted a safe environment when she left the room and failed to maintain visibility of the access point.

To determine which sanction applies in this matter, Ms. Riley used the disciplinary matrix. Ms. Riley testified she considered the facts and decided, based on the mitigating circumstances and aggravating factors, the tier and sanction level. Here, for both subsections (b)(10) and (b)(14), she determined the second tier and sanction level two are the most appropriate.

She chose tier two for the subsection (b)(10) violation because there was a failure on Respondent's part to provide safe care to G.C., placing G.C. at a serious risk of harm.

In determining the sanction levels for violations of subsections (b)(10) and (b)(14), she testified that she considered all the factors under Board Rule 213.33(c). Specifically, she noted that Respondent has a prior Board order from when she was a new nurse practicing for only four months.[44] Respondent has been in dialysis setting since May 2017, and she would have expected a nurse with that level of experience to implement nursing interventions for patient safety.[45] A patient died as a result of the violation.[46] Ms. Riley noted that while leaving the room might not have directly caused the line disconnection, Respondent did leave the room. Respondent was also on the phone before noticing the blood. Not noticing the disconnection in time and not having visibility of the line led to Respondent not being able to see the disconnection.[47] The violations are serious.[48] Ms. Riley noted the mission of the board is to protect the public. She was not convinced that Respondent knows how to prevent this from occurring in the future or that she learned from this event. [49]

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[44] 22 Tex. Admin. Code § 213.33(c)(6).

[45] 22 Tex. Admin. Code § 213.33(c)(7).

[46] 22 Tex. Admin. Code § 213.33(c)(1).

[47] 22 Tex. Admin. Code § 213.33(c)(10).

[48] 22 Tex. Admin. Code § 213.33(c)(14).

[49] 22 Tex. Admin. Code § 213.33(c)(15).

1. Recommended Sanction

Ms. Riley recommended an enforced suspension. Respondent would have to complete certain conditions prior to returning to practice as a nurse. Specifically, she recommended remedial education courses: a nursing jurisprudence and ethics course, critical thinking course, professional accountability course, and documentation course. Once completed, Ms. Riley then recommended three years of supervision: one year of direct supervision and two years of indirect supervision.

Ms. Riley also recommended requiring quarterly evaluations from Respondent's employer during the supervision period in order to help reassure the Board and the public that Respondent is competent to practice safely and that someone would intervene as necessary.

Ms. Riley is aware that since May 30, 2022, Respondent has worked autonomously and without supervision and there have been no incidents or reports of safety concerns. She has also seen Respondent's performance review from DaVita. Although aware that acute dialysis nurses often work autonomously, Ms. Riley believes Respondent would benefit from a period of supervision and said the supervision would not prohibit her from working as a dialysis nurse.

2. Respondent's Position

Respondent and her witnesses testified that it would be impossible to provide the supervision recommended by the Board for the following six reasons. First, Respondent is a contract dialysis nurse who works in small hospitals that do not have their own dialysis units or another dialysis nurse in the hospitals. She works

autonomously. Since DaVita operates based on patient need at each hospital, it cannot guarantee there would always be someone there to fulfill the supervisory role or that there would be another dialysis nurse in the hospital who can fulfill the supervisory role. According to Mr. Vazhachira, four out of the Denton's team five hospitals have no option for a nurse to work side by side while the fifth hospital cannot guarantee there will be someone who can supervise Respondent because the patients are not necessarily dialyzed at the same time and, due to the urgency of certain cases, the other nurse may have to leave the dialysis suite or the hospital. Plus, the acute dialysis nurses in his group are sometimes the only dialysis provider in the hospital.

Second, Ms. Johnson and Respondent had researched opportunities in the acute dialysis field, and both testified that there are no opportunities in Respondent's geographical area where she can be supervised as an acute or chronic dialysis nurse. They believe that if Respondent is placed on supervision, no Texas dialysis clinic or hospital can guarantee she can be supervised.

Third, there is a nursing shortage in the dialysis field, as testified to by Ms. Christmas and Mr. Vazhachira. They assert the acute dialysis world needs nurses like Respondent, who provide compassionate care and know the expectations of a dialysis nurse. The fact that Respondent has continued to provide inpatient dialysis shows Ms. Christmas that Respondent has a lot of compassion and has a high level of commitment to her profession. Moreover, Mr. Vazhachira testified that acute dialysis nurses are expected to manage varying conditions (e.g., dialyze in the ICU or ER) and critical patients who arrive at the hospital with conditions they have to

handle (e.g., poisoning or hyperkalemia). Such situations need a well-trained dialysis nurse like Respondent.

Fourth, Respondent's witnesses also asserted she did not need to be supervised since she has worked autonomously with no issues involving Respondent's care of her patients since the incident. Dr. Rojas said he had no reason to question Respondent's judgement or the way she manages her patients. In Mr. Vazhachira's opinion, Respondent is safely able to practice nursing in an autonomous role and make appropriate decisions regarding her patients since she exercises good nursing judgment and is not a threat to public safety. Respondent testified she has continued to work with DaVita as a charge nurse and as a preceptor since May 30, 2022.

Fifth, Respondent's supervisors and the physician witnesses opined that if Respondent is unable to continue as an acute dialysis nurse under the Board's conditions, the greatest impact would be to the patients whom she treats. The physicians also believed it would be a big loss to the physicians and the hospitals. According to Dr. Jalandhara, "the loss is going to be much more than just losing one nurse."[50] He explained that dialysis nurses, especially those who have just started in this career, look towards Respondent for guidance. Dr. Rojas also noted it takes a special kind of nurse to be a dialysis nurse because the patients require a different kind of care. He opined that it would "be sad for the dialysis population to lose a nurse like [Respondent]."[51] Ms. Johnson also stated that Respondent is one of those

[50] Transcript day 2 at 126.

[51] Transcript day 2 at 200.

very few people who truly care about people and truly want to do the right things. If ordered to be supervised, Mr. Vazhachira testified Respondent will not be able to continue as a part of his team.

Finally, regarding the 2019 Board Order for Respondent's medication error, Ms. Christmas noted Respondent had only been a practicing nurse for a few months at that time. She testified that when nurses get out of nursing school, they are not qualified to provide direct patient care. Instead, they are usually assigned to a preceptor who serves as a guide or mentor. Unfortunately, mistakes sometimes happen, especially with new nurses and those who have not received adequate training or guidance. In her opinion, the Board Order should not be considered in determining an appropriate sanction for Respondent because she has gained experience over the years, has become an outstanding leader, has received a lot of awards and accolades, and is a great team member and team leader. She thinks Respondent's experience over the years have made a difference.

IV. ANALYSIS

A. FAILURE TO REMAIN IN THE ROOM DURING DIALYSIS AND FAILURE TO ENSURE THE ACCESS SITE WAS UNCOVERED AND WAS APPROPRIATELY MONITORED

Staff asserts Respondent violated minimum nursing standards and engaged in unprofessional conduct by failing to remain in the patient's room during the duration of the patient's one-on-one dialysis treatment. Respondent did not dispute she left the patient's room and expressed remorse for her actions. She did not let the floor nurse retrieve the dressing kit for her or have someone watch G.C. while she left the

room. It is uncontroverted that the dialysis catheters and access site were not visible to Respondent while she was out of the room. Although the evidence establishes that Respondent did not meet the standard of care when she left G.C. unattended, the evidence also established that the disconnection of G.C.'s line did not happen while Respondent was out of the room. In fact, Respondent used the dressing kit retrieved from the storage room to change G.C.'s dressing after returning to the room.

The risky nature of acute dialysis necessitates not only that the nurse be present in the room for the entirety of the process, but also that the access site remain uncovered and the patient be monitored visually and audibly at all times.[52] The ALJ agrees that it would be impossible for a nurse to stare at the access site and connections for the entire duration of the several-hours-long process while still documenting, changing the dressing, and monitoring the dialysis machine; however, the ALJ also concludes that minimum standards of nursing practice require more frequent monitoring of the site and lines than the every 15-minute documentation requirement. It is undisputed that when the blood was discovered dripping on the floor, G.C.'s access site was covered by a blanket, which the nurses removed to find that the line had been disconnected. Although it is not known how long the site and lines had been covered or at least not visually monitored by Respondent, it was long enough for G.C.'s blood to soak the bed and drip onto the floor. The ALJ concludes that Respondent failed to visually monitor the patient's access site and lines with sufficient frequency to discover that it had been covered and discover and respond to the disconnection of G.C.'s line. The ALJ, however, does not conclude that Staff proved by a preponderance of the evidence that Respondent's actions caused G.C.

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[52] Staff Ex. 7 at 6.

to expire shortly after the line was found disconnected. G.C. was a small person who, consequently, had a low blood volume—a not insignificant portion of which was outside her body and inside the dialysis machine during the procedure. It would only have taken a brief moment for the patient to lose significant blood once the line became disconnected. G.C. was conscious at the time the disconnection was discovered, and Respondent took appropriate action afterwards to re-connect the line and call a Code Blue.

Respondent is therefore subject to discipline by the Board pursuant to Texas Occupation Code section 301.452(b)(10) for engaging in unprofessional conduct, and pursuant to section 301.452(b)(13) for failing to meet minimum standards of nursing practice.

B. SANCTION ANALYSIS

The Disciplinary Matrix categorizes violations into three tiers, in ascending order of seriousness, and two sanction levels within each tier. At the hearing, Ms. Riley testified that, in her opinion, Respondent's violation falls within Tier Two and Sanction Level II under both Texas Occupations Code section 301.452(b)(10) and (14).

When sanctioning for unprofessional conduct pursuant to Texas Occupations Code section 301.452 (b)(10), Tier One applies to unprofessional conduct resulting in unsafe practice with no adverse patient effects and Tier Two applies unprofessional conduct resulting in serious risk to patient. The ALJ agrees that Tier Two applies, because, as discussed above, Respondent both left the room and did not

sufficiently monitor the access site or lines, resulting in a serious risk to G.C. Though the ALJ agrees that the risk to the patient was serious, the ALJ does not believe that Staff proved that her actions caused the patient's demise and recognizes that it could only have taken a brief moment for the patient to lose significant blood after the line became disconnected.

When sanctioning for failure to conform to minimum nursing standards pursuant to Texas Occupations Code section 301.452(b)(14), Tier One applies to violations with a low risk of patient harm and Tier Two applies to when a nurse's violation results in patient harm or risk of patient harm. In this case, the violation consists of actions that resulted in risk of harm—risk that G.C. could disconnect a line, her blood pressure could go down, or the dialysis machine could malfunction. Therefore, a second-tier sanction is appropriate.

Within the tiers for both failures to conform to minimum standards and unprofessional conduct, the Board must select Sanction Level I or II based upon the aggravating and mitigating factors in the Disciplinary Matrix and those listed in Board Rule 213.33(c).[53] If multiple violations are present, the Disciplinary Matrix directs that the most severe sanction recommended for any of the violations should be considered.[54]

Tier Two for violation of Texas Occupations Code section 301.452(b)(10) permits the Board to require a warning or reprimand with stipulations that can

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[53] Board Rule 213.33(b)-(c).

[54] Board Rule 213.33(c).

include remedial education and supervised practice under Sanction Level I or suspension, probated suspension, or revocation under Sanction Level II.

Tier Two for violation of Texas Occupations Code section 301.452(b)(14) permits the Board to issue a warning or reprimand with stipulations that may include supervised practice, limited specific nursing activities and/or periodic board review and/or a fine under Sanction Level I or suspend, deny, or revoke the nurse's license or request for voluntary surrender of the nurse's license under Sanction Level II.

Staff pointed to a number of aggravating factors that must be considered, including the fact that there were multiple violations, such as failure to notice the disconnection in time, failure to have the line visible, and leaving the room during the procedure. Ms. Riley also testified that Respondent, who had been practicing for five years at the time of the incident, should have had a level of experience to implement nursing interventions for patient safety. Here, it would have been visually monitoring the access site and connections more frequently and having someone sit with the patient when she left the room or stay in the room while the floor nurse retrieved the dressing kit. Staff also noted Respondent's prior Board order, which she received as a new nurse practicing for only four months. Respondent had successfully complied with the terms under the Agreed Order. Patient vulnerability is also an aggravating factor in this case, because G.C. was extremely vulnerable as a bed-ridden, frail octogenarian with multiple comorbidities who was nonverbal at baseline. Finally, Ms. Riley blamed Respondent for G.C.'s death. Specifically, she claimed that Respondent did not notice the disconnection in time, did not have

visibility of the line therefore did not see the disconnection, and was on the phone before noticing the blood.

As for mitigating factors that might warrant a lower sanction, Ms. Riley did not testify to any. However, the evidence established Respondent has been working autonomously since G.C.'s death without any other known violations. Respondent's evaluations and testimonies from her supervisors and the physicians whom she has worked with established her fitness to practice and nursing competency, as further demonstrated by her leadership and preceptorship positions, as well as the accolades she has received.

Taking these aggravating and mitigating factors into consideration, the ALJ finds that Respondent's violations best fit under the Second Tier, Sanction Level I for violations of Texas Occupations Code section 301.452(b)(10) and (b)(14).

As a sanction, Ms. Riley did not recommend revoking Respondent's license. Rather, she testified that an enforced suspension would remediate Respondent's practice. The recommended suspension would be enforced until Respondent completed the following remedial education courses: nursing jurisprudence and ethics, critical thinking, professional accountability, and documentation. Upon completion of those courses, Respondent's license would be probated for three years of supervision with quarterly evaluations required from Respondent's employer during the supervision period. Respondent would submit to direct supervision the first year, meaning her supervisor is present on the unit when Respondent is working; and indirect supervision for the last two years, meaning a supervisor is on the

premises but not necessarily in the unit. Ms. Riley testified that her recommendation would address the Board's concerns about Respondent's training and experience and would allow her to continue working while under probation.

The ALJ agrees the educational requirements, quarterly evaluations, and supervised practice are reasonably targeted to address the violation and ensure that Respondent is safe to practice independently again. However, Staff's recommendation is based partly on violations it did not allege in the Formal Charges. And as discussed above, Respondent's actions did not cause G.C.'s death. Moreover, Respondent has not left a patient unattended since that date nor had issues with patient care; instead, the evidence established her fitness to practice.

Accordingly, the ALJ concludes the Board should sanction Respondent's conduct under Tier Two Sanction Level I for violation of Texas Occupations Code sections 301.452(b)(10) and (b)(14), which would permit the Board to issue a warning with stipulations that may require remedial education and supervised practice. The ALJ recommend remedial education courses of a nursing jurisprudence and ethics course, critical thinking course, and professional accountability and one year of indirect supervision.

V. FINDINGS OF FACT

1. Merri Lou Guzaitis (Respondent) received Registered Nurse (RN) License No. 914209 in January 2017 from the Texas Board of Nursing (Board).

2. In 2019, Respondent received a disciplinary action from the Board for her actions in April 2017 and for when she was a new nurse practicing for only four months. While employed at Life Care Hospital, Respondent failed to promote

a safe environment by not using two patient identifiers before administering medications to a patient and failed to verify a new physician's order before attempting to administer the medication, which was ordered not to be given until the next day. Both actions exposed the patient to a risk of harm. The disciplinary action resulted in an Agreed Order Deferred Discipline and completion of the Knowledge, Skills, Training, Assessment and Research (KSTAR) Program. Respondent acknowledged accountability for her actions and completed the terms under the Agreed Order.

3. On May 30, 2022, Respondent, employed by DaVita Kidney Care (DaVita) as a dialysis nurse, preceptor, and charge nurse, worked as an acute dialysis nurse at Texas Health Presbyterian Flower Mound, Flower Mound, Texas (Texas Health Presbyterian). That day Respondent provided one-on-one contract dialysis services for Patient G.C.

4. G.C. was a 90-pound, non-ambulatory octogenarian progressing towards hospice care. She had multiple comorbidities that included dementia and chronic kidney disease. She had muscle contractures which kept her in a fetal position. Her legs were contracted to her chest and her arms also tucked up to her chest with her hands in the middle of her chest. Although she could not fully extend her arms, she could move them out a few inches after which they returned to her chest. G.C.'s dialysis access site was on her chest.

5. G.C.'s hemodialysis started at 12:15.

6. At 12:30, Respondent increased the blood flow rate to the ordered rate.

7. Hemodialysis was "progressing well" at 12:45.

8. At 13:00, Respondent noted that the vascular access site and line connections were visible and secure.

9. At 13:15 Respondent repositioned G.C.

10. Respondent requested a dressing kit from the floor nurse. Respondent left G.C.'s room to follow the floor nurse to the supply room to retrieve the kit. After retrieving the dressing change kit, they returned to G.C.'s room and changed the sterile dressing at 13:30.

11. After changing the dressing, Respondent sat next to G.C.'s bed, held her hand, and spoke reassurances to her until G.C. fell asleep. While sitting next to G.C., Respondent was still able to see the line connections.

12. After at least five minutes of sitting next to G.C., Respondent received a phone call. Respondent believed it was safe to take the call because G.C. was sound asleep and not moving.

13. The first call lasted about a minute or two: a nurse had called about a new patient in the emergency room who needed to be urgently dialyzed. Respondent called another nurse to schedule the new patient for urgent dialysis. The third and final call was made to the original nurse to tell her which nurse would take the new patient.

14. At 13:40, Respondent and the floor nurse noticed a "small amount of blood dripping on the floor" near where Respondent stood at G.C.'s bedside.

15. After pulling down G.C.'s blanket, which had been pulled up to her chin, they discovered the venous lumen catheter, which carries blood back to the patient, had been disconnected and blood had pooled on G.C.'s left side. G.C. was conscious at the time the disconnection was discovered. The catheter was reattached. A Rapid Response Team was called, and later the Code Blue team; however, G.C. subsequently expired after unsuccessful attempts in resuscitating her.

16. DaVita investigated the May 30, 2022 incident and disciplined Respondent with a verbal warning for leaving G.C.'s the room to get a sterile bandage but did not discipline her for the line disconnection.

17. Respondent continued to work autonomously and with no practice issues for DaVita after May 30, 2022, as a preceptor, charge nurse, and team leader and received accolades for her dedication to her team and her patients. Respondent established her fitness to practice and nursing competency.

18. Staff issued a Notice of Hearing on November 7, 2023, and the Administrative Law Judge (ALJ) issued Order No. 3 on January 12, 2024, that granting a motion for continuance rescheduled the hearing to May 2024. Together they contained a statement of the time, place, and nature of the hearing; a statement of the legal authority and jurisdiction under which the hearing was to be held;

a reference to the particular sections of the statutes and rules involved; and either a short, plain statement of the factual matters asserted or an attachment that incorporated by reference the factual matters asserted in the complaint or petition filed with the state agency.

19. State Office of Administrative Hearings (SOAH) ALJ Dee Marlo Chico of the convened the hearing on the merits by videoconferencing on May 8-9, 2024. Assistant General Counsel JoAnna Starr represented Staff. Respondent appeared, and attorney Brenda Damuth represented her. The record closed on July 1, 2024, with the filing of Staff's rebuttal brief.

VI. CONCLUSIONS OF LAW

1. The Board has jurisdiction over the licensing and discipline of nurses. Tex. Occ. Code ch. 301.

2. SOAH has jurisdiction over contested cases referred by the Board, including the authority to issue a proposal for decision with findings of fact and conclusions of law. Tex. Occ. Code § 301.459; Tex. Gov't Code ch. 2003.

3. Respondent received adequate and proper notice of the hearing on the merits. Tex. Occ. Code § 301.454; Tex. Gov't Code §§ 2001.051-.052.

4. By failing to remain in the patient's room for the duration of the patient's one-on-one dialysis treatment and failing to adequately monitor the access site and lines, Respondent violated the minimum standards in 22 Texas Administrative Code section 217.11(1)(A)-(C), (1)(M), and (3) and engaged in unprofessional conduct as defined by 22 Texas Administrative Code section 217.12(1)(A)-(B) and (4).

5. The Board may impose a disciplinary sanction, which can range from remedial education to revocation of a nurse's license, and which may include assessment of a fine. Texas Administrative Code § 301.453; 22 Tex. Admin. Code § 213.33(e).

6. To determine the appropriate disciplinary sanction to be imposed in this case, the Board must consider the factors, including aggravating and mitigating

circumstances, set forth in 22 Texas Administrative Code section 213.33(c) and the Board's Disciplinary Matrix. 22 Tex. Admin. Code § 213.33(b).

7. Respondent's conduct most appropriately falls in Tier Two, Sanction Level I under Texas Occupations Code section 301.452 (b)(10) and Tier Two, Sanction Level I under Texas Occupations Code section 301.452(b)(14). 22 Texas Admin. Code § 213.33(b).

8. The Board should issue a warning order requiring Respondent to take courses in nursing jurisprudence and ethics, critical thinking, and professional accountability, and requiring one year of indirect supervision.

Signed August 30, 2024

ALJ Signature:

DMChico

Dee Marlo Chico

Presiding Administrative Law Judge

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Status as of 8/30/2024 11:30 AM CST

Associated Case Party: TEXAS BOARD OF NURSING

Name	BarNumber	Email	TimestampSubmitted	Status
Cynthia LLoCastro		cynthia.locastro@bon.texas.gov	8/30/2024 11:25:28 AM	SENT
JoAnna Starr		joanna.starr@bon.texas.gov	8/30/2024 11:25:28 AM	SENT
Alyssa Kim		Alyssa.Kim@bon.texas.gov	8/30/2024 11:25:28 AM	SENT

Associated Case Party: MERRILOUGUZAITIS

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Texas Board of Nursing

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Kristin K. Benton, DNP, RN
Executive Director

September 12, 2024

The Honorable Dee Marlo Chico, Administrative Law Judge
State Office of Administrative Hearings
P.O. Box 13025
Austin, Texas 78711-3025

via electronic filing

Re: SOAH Docket No. **507-23-24298**
In the Matter of Permanent Certificate No. **RN 914209**
Issued to: **MERRI LOU GUZAITIS**

Dear Judge Chico:

Please accept this letter brief as Staff's Exceptions to the Proposal for Decision in the above-referenced matter. First, a minor exception, the ALJ references Staff expert Dr. Das as a male with the pronoun "he." Staff would like to clarify that Dr. Das is a female and should be referred to as a "she."

Second, Staff excepts to Conclusions of Law Numbers Seven (7) and Eight (8) below:

7. Respondent's conduct most appropriately falls in Tier Two, Sanction Level I under Texas Occupations Code section 301.452 (b)(10) and Tier Two, Sanction Level I under Texas Occupations Code section 301.452(b)(14). 22 Texas Admin. Code § 213.33(b).

8. The Board should issue a warning order requiring Respondent to take courses in nursing jurisprudence and ethics, critical thinking, and professional accountability, and requiring one year of indirect supervision.[1]

Texas Occupations Code §301.459(a-1) makes clear that "the administrative law judge may **make a recommendation** regarding appropriation action or sanction" but "the board has the **sole authority** and discretion to determine the **appropriate action or sanction**." This authority has been routinely upheld by Texas courts:[2] "An agency has broad discretion in determining which

[1] Proposal for Decision p. 52.
[2] See *Sears v. Tex. State Bd. of Dental Exam'rs*, 759 S.W.2d 748, 751, 851 (Tex.App.—Austin 1988, no writ) ("[T]he choice of penalty is vested in the agency, not in the courts." and "The agency is charged by law with discretion to fix the penalty when it determines that the statute has been violated."); *Tex. State Bd. of Pharmacy v. Witcher*, 447 S.W.3d 520, 525 (Tex.App.—Austin 2014) ("Although the Board may consider an ALJ's

sanction best serves the statutory policies committed to the agency's oversight."[3] *Texas State Board of Dental Examiners v. Misty J. Brown, D.D.S.*,[4] specifically addresses whether an agency is bound to follow an "ALJ's disciplinary recommendation ... set out as a conclusion of law rather than as a recommendation."[5] The court held that "the mere labeling of a recommended sanction as a conclusion of law or as a finding of fact does not change the effect of the ALJ's recommendation."[6] In *Sejoon Kim, M.D. v. State Board of Dental Examiners*,[7] the court considered whether the agency was able to change a conclusion of law which designated the placement in the agency's disciplinary matrix.[8] The court held that application of the disciplinary matrix is also left to the ultimate determination of the agency, by finding that the only issue in this case was "whether the Board correctly construed its own matrix when deciding the appropriate sanction to impose."[9] Ultimately, the court upheld the agency's application of the disciplinary matrix, finding that "the Board chose one of the permissible sanctions authorized by a chart at issue."[10]

The ALJ's labeling of these recommendations as conclusions of law would force the Board to expend unnecessary resources to protect its right to determine sanction and undermines the Board's statutory sole authority to do so. *Texas State Board of Dental Examiners v. Misty J. Brown, D.D.S.*, further explains that the ALJ's choice "to set out her sanction recommendation as a conclusion of law" necessarily implicates the constricted procedures of Texas Government Code §2001.058(e) for modification of a finding of fact or conclusion of law within a PFD.[11] However, under Texas Occupations Code §301.459(a-1), in order for the Board to modify or vacate the ALJ's inappropriately labeled conclusions of law, the Board may have to "obtain judicial review ... as provided by Section 2001.058(f)(5), Government Code." This could incur additional, unnecessary expense to the Board, the state of Texas, and its citizens. ALJ

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recommendation regarding the sanction to be imposed, the Board retains discretion to determine the appropriate sanction."); *Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 781 (Tex.App.—Austin 2005, pet. denied) ("We agree with the Board that it is not required to give presumptively binding effect to an ALJ's recommendations regarding sanctions in the same manner as with other findings of fact and conclusions of law.")

[3] *Fay-Ray Corp. v. Tex. Alcoholic Beverage Comm'n*, 959 S.W.2d 362, 369 (Tex.App—Austin 1998, no pet.). See also *Austin Chevrolet, Inc. v. Motor Vehicle Bd*, 212 S.W.3d 425, 438 (Tex.App.—Austin 2006, pet. denied) ("Policy considerations ... are the reason that the Commission is granted discretion over what penalties should be imposed for racing violations.").

[4] *Tex. State Bd. of Dental Exam'rs v. Brown*, 281S.W3d 692 (Tex.App—Corpus Christi-Edinburg 2009).

[5] *Id.* at 697.

[6] *Id.* See also *Froemming v. Tex. State Bd. of Dental Exam'rs*, 380 S.W.3d 787, 792 (Tex.App.—Austin 2012, no pet.); *State Bd. for Educator Cert. v. Bowen*, NO. 07-22-00190-CV, 1-2 (Tex.App.—Amarillo 2023, mem. op.).

[7] *Sejoon Kim, M.D. v. State Board of Dental Examiners*, NO. 03-13-00499-CV (Tex.App.—Austin 2015, mem. op.).

[8] *Id.* at 5-6.

[9] *Id.* at 7-11.

[10] *Id.* at 13.

[11] See *Tex. State Bd. of Dental Exam'rs v. Brown* at 698. See also *Akin v. State Bd. of Dental Exam'rs*, NO. 03-14-003900-CV, 12-13 (Tex.App.—Austin 2015, mem. op.); *State Bd. for Educator Cert. v. Bowen* at 9.

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Kristin K. Benton, DNP, RN
Executive Director

recommendations of sanctions, improperly labeled as findings of facts or conclusions of law, have the potential to cause a litany of appellate litigation each time the Board enforces its right determine appropriate sanction in accordance with the policies committed directly to its inimitable oversight. The ALJ may still offer a recommendation for sanction in the PFD, under a separate section, which is not labeled as a conclusion of law.

THEREFORE, Staff would respectfully propose the removal of Conclusions of Law Seven (7) and Eight (8), with the ALJ's recommendation for sanction offered in an appropriate section of the PFD, and the modification of any references to Dr. Das from "he" to "she."

Respectfully submitted,

TEXAS BOARD OF NURSING

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CERTIFICATE OF SERVICE

I hereby certify that a true copy of the foregoing *Staff's Exceptions to Proposal for Decision* was sent via electronic filing and email on this, the 12th day of September 2024, to: Brenda J. Damuth, Attorney at Law, via email: Brenda.damuth@wilsonelser.com

JoAnna Starr, Assistant General Counsel

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Alyssa Kim on behalf of JoAnna Starr
Bar No. 24098463
alyssa.kim@bon.texas.gov
Envelope ID: 91941501
Filing Code Description: Exceptions to PFD
Filing Description: Staff's Exceptions to PFD
Status as of 9/12/2024 12:26 PM CST

Associated Case Party: TEXAS BOARD OF NURSING

Name	BarNumber	Email	TimestampSubmitted	Status
JoAnna Starr		joanna.starr@bon.texas.gov	9/12/2024 10:47:26 AM	SENT
Alyssa Kim		Alyssa.Kim@bon.texas.gov	9/12/2024 10:47:26 AM	SENT

Associated Case Party: MERRILOUGUZAITIS

Name	BarNumber	Email	TimestampSubmitted	Status
Sally Martens		sally.martens@wilsonelser.com	9/12/2024 10:47:26 AM	SENT
BRENDA DAMUTH		BRENDA.DAMUTH@WILSONELSER.COM	9/12/2024 10:47:26 AM	SENT
Stephanie Canada		stephanie.canada@wilsonelser.com	9/12/2024 10:47:26 AM	SENT

State Office of Administrative Hearings

Kristofer S. Monson
Chief Administrative Law Judge

October 4, 2024

JoAnna Starr, Attorney for Petitioner **VIA EFILE TEXAS**

Brenda Damuth, Attorney for Respondent **VIA EFILE TEXAS**

RE: Docket Number 507-23-24298; *Texas Board of Nursing v. Merri Lou Guzaitis*

Dear Parties:

The proposal for decision (PFD) was issued in this case on August 30, 2024. Staff (Staff) of the Texas Board of Nursing (Board) timely filed exceptions to the PFD. Merri Lou Guzaitis (Respondent) did not file exceptions or a response to Staff's exceptions.

I agree with Staff that Conclusions of Law (COL) Numbers 7 and 8 should be removed and that I can add a separate section addressing my recommendation for sanction. Accordingly, I recommend removing COLs Nos. 7 and 8 and adding the following section:

VI. RECOMMENDATION

Based on the findings of fact and conclusions of law, the ALJ recommends the Board issue a warning requiring Respondent to take courses in nursing jurisprudence and ethics, critical thinking, and professional accountability, and requiring one year of indirect supervision.

I also recommend adding the following COL to the PFD:

7. The Board may consider as mitigating factors: Respondent has been working autonomously since G.C.'s death without any other known violations; and Respondent's evaluations and testimonies from her supervisors and the physicians whom she has worked with established her fitness to practice and nursing competency, as further demonstrated by her leadership and preceptorship positions, as well as the accolades she has received. 22 Tex. Admin. Code § 213.33(b)-(c).

Finally, Staff noted a clerical error regarding Dr. Dolan Chapas Das. The PFD referred to Dr. Das using the male pronoun when the female pronounce should have been used. I regret this error and agree these typographical errors should be corrected to reflect Dr. Das is female.

The PFD, with the changes noted above, is ready to be presented to the Board for a final decision.

ALJ Signature(s):

DMChico

Dee Marlo Chico

Presiding Administrative Law Judge

CC: Service List

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Associated Case Party: TEXAS BOARD OF NURSING

Name	BarNumber	Email	TimestampSubmitted	Status
JoAnna Starr		joanna.starr@bon.texas.gov	10/4/2024 10:45:41 AM	SENT
Alyssa Kim		Alyssa.Kim@bon.texas.gov	10/4/2024 10:45:41 AM	SENT

Associated Case Party: MERRILOUGUZAITIS

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Sally Martens		sally.martens@wilsonelser.com	10/4/2024 10:45:41 AM	SENT
BRENDA DAMUTH		BRENDA.DAMUTH@WILSONELSER.COM	10/4/2024 10:45:41 AM	SENT
Stephanie Canada		stephanie.canada@wilsonelser.com	10/4/2024 10:45:41 AM	SENT